COVE FREEDOM
CHIROPRACTIC

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Full Name : _____
FIRST **LAST** **MI**

Date of Birth : ____/____/____ **Gender** : ☐ Male ☐ Female

Address : _____

_____
City **State** **Zip Code**

Home Number : _____ **E-Mail** : _____

Cell Number : _____

Status : ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated

ID/Driver's License# : _____ **State** _____

Occupation : _____ **Retired?** : ☐ Yes ☐ No

Employer : _____ **Work Number** : _____

Employer Address _____

_____
City **State** **Zip Code**

Spouse's Name : _____ **Home Number** : _____

Mobile Number : _____

Are you the parent or legal guardian of the patient?

☐ YES ☐ NO

Name : _____

Relationship to Patient : _____

More Information :
211Liberty Bell Lane, Suite 111
Copperas Cove, TX 76522
(254) 547-6654 (Office)
www.covefreedom.com

THANK YOU

WELLNESS SCORE EXAM FORM **COVE FREEDOM CHIROPRACTIC**

Name: _____ ***Date:*** _____

(First) **(Last)** **(MI)**

Referred by: _____

What brings you to the office today? PS-Pain Scale 1-10

1._____ _____PS____

2._____ PS____

3._____ PS____

4._____ _____PS____

Quality: Sharp Dull Pins & Needles Stiffness Burning Ache Throbbing Other_____

Current Meds/_____

_____

How many **meds** do you take?____

Rx Name/Condition:_____

_____

_____

_____

Does it: Come and Go Constant Other_____

Supplements _____

Onset: Date:_____ Acute Chronic Re-aggravation

Getting: Better Worse Same

Nerve pressure (Radiating)? [Y][N] [R] [L] [Arm] [Leg]

What do you do in a typical day's work/repetitive motions/posture/sitting/how many hours?

_____

_____

What does the problem feel like?

_____

_____

Does this problem involve trauma? If so circle: (Auto Accident / Worker Comp / Other) Date of trauma_____

_____

Did you go to the Hospital?_____

X-rays taken? _____ Were you adjusted after this Trauma? Yes No

What other things have you done for this condition?_____

HEATLH CARE CONTINUUM

If I had a "magic wand" and could change anything about your health, what are your health goals (be specific)?

1._____2._____3._____

How would you describe your _____ on a scale of 1-10 with 1 being poor and 10 being excellent?

Exercise_____ Sleep_____ Diet _____ Stress Level_____ Water_____ General Health_____

The following 3 supplements are what we call the big three because they are critical to your health and research shows that most Americans are deficient in them. So, do you take the following?

Omega 3 Fatty Acid (Fish Oil): Yes No Vitamin B Complex: Yes No Probiotics: Yes No

Do you take a whole food multivitamin? Yes No

Have you seen a Chiropractor before?_____Good/Bad Experience? Last Adjustment? _____

Last blood work?_____MD_____

Specialist_____ _____

Today we are going to do a complete health assessment and complete something we call a wellness score. Are there any other doctors you would like us to mail this to? Yes No Who?_____

Additional Notes:

_____

_____

_____

_____

Medical Symptoms Questionnaire (MSQ)

Name: _____ Date: _____

Email Address: _____

Rate each of the following symptoms based upon your typical health profile for the **past 30 days**.

Point Scale
0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

Head
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
Total _____

Eyes
_____ Watery or Itchy Eyes
_____ Swollen, Reddened or Sticky Eyelids
_____ Bags or Dark Circles Under Eyes
_____ Blurred or Tunnel Vision
(does not include near or far-sighted)
Total _____

Ears
_____ Itchy Ears
_____ Earaches, Ear Infections
_____ Drainage from Ear
_____ Ringing in Ears, Hearing Loss
Total _____

Nose
_____ Stuffy Nose
_____ Sinus Problems
_____ Hay Fever
_____ Sneezing Attacks
_____ Excessive Mucus Formation
Total _____

Mouth/ Throat
_____ Chronic Coughing
_____ Gagging, Frequent Need to Clear Throat
_____ Sore Throat, Hoarseness, Loss of Voice
_____ Swollen or Discolored Tongue, Gums, or Lips
_____ Canker Sores
Total _____

Skin
_____ Acne
_____ Hives, Rashes, Dry Skin
_____ Hair Loss
_____ Flushing, Hot Flashes
_____ Excessive Sweating
Total _____

Heart
_____ Irregular or Skipped Heartbeat
_____ Rapid or Pounding Heartbeat
_____ Chest Pain
Total _____

Lungs
_____ Chest Congestion
_____ Asthma, Bronchitis
_____ Shortness of Breath
_____ Difficulty Breathing

Total _____

Digestion
_____ Nausea, Vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated Feeling
_____ Belching, Passing Gas
_____ Heartburn
_____ Intestinal/Stomach Pain

Total _____

Joints/ Muscles
_____ Pain or Aches in Joints
_____ Arthritis
_____ Stiffness or Limitation of Movement
_____ Pain or Aches in Muscles
_____ Feeling of Weakness or Tiredness

Total _____

Weight
_____ Binge Eating/Drinking
_____ Craving Certain Foods
_____ Excessive Weight
_____ Compulsive Eating
_____ Water Retention
_____ Underweight

Total _____

Energy/ Activity
_____ Fatigue, Sluggishness
_____ Apathy, Lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

Mind
_____ Poor Memory
_____ Confusion, Poor Comprehension
_____ Poor Concentration
_____ Poor Physical Condition
_____ Difficulty in Making Decisions
_____ Stuttering or Stammering
_____ Slurred Speech
_____ Learning Disabilities

Total _____

Emotions
_____ Mood Swings
_____ Anxiety, Fear, Nervousness
_____ Anger, Irritability, Aggressiveness
_____ Depression

Total _____

Other
_____ Frequent Illness
_____ Frequent or Urgent Urination
_____ Genital Itch or Discharge

Total _____

Grand Total _____

Health Satisfaction Score (HSS)

Name: _____ Date: _____

Email Address: _____

Please answer the questions on a scale of 1 to 10, 1 representing that you don't agree with the statement and 10 representing that there is no doubt in your mind or heart that you agree with the statement.

[1 - Absolutely Disagree] [2] [3] [4] [5] [6] [7] [8] [9] [10 - Absolutely Agree]

Section 1 - Physical Health

1. I am a physically fit person and formally exercise on a regular basis.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
2. I have a physically attractive body that I am proud to look at in the mirror.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
3. I have not had many traumas in my life (auto accident, broken bones, bad falls).
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
4. I get at least 7 hours of sleep, 7 days at week
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
5. I have gotten regular Chiropractic care within the past 5 years.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 1 total _____

Section 2 - Emotional/Mental Health

6. I am a calm, peaceful person. I can shut my mind off and focus my mind at will.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
7. I practice some form of mental relaxation (meditation, yoga, breathing exercises, prayer, etc.) on a regular basis.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
8. Most of the time, I am truly happy and feel a sense of purpose in my life.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
9. I have healthy relationships and a rich social network of friends and activities.
   [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
10. I am organized, have time for myself, and can prioritize the important tasks in my life.
    [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 2 total _____

Section 3 - Chemical/Nutritional Health

11. I eat 4-6 small meals daily and properly combine my protein, carbs. and fats.
    [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
12. I supplement everyday with good supplements such as a vitamin/mineral complex, antioxidants, and good fatty acids (fish oil, flax seeds).
    [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
13. I do not take medications for chronic medical problems such as digestive disorders; cardiovascular problems; headaches; chronic pain; blood sugar problems; chronic fatigue; immune problems or chronic infections; or any other chronic conditions.
    [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
14. I do not smoke cigarettes.
    [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]
15. I drink water as my primary beverage and consume at least 30 ounces per day.
    [1] [2] [3] [4] [5] [6] [7] [8] [9] [10]

Section 3 total_____

Grand total of all three sections: _____

Informed Consent for Chiropractic Treatment

TO THE PATIENT: *You have a right to be informed about your condition, the recommended chiropractic treatment, and the potential risks involved with the recommended treatment. This information will assist you in making an informed decision whether or not to have the treatment. This information is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or refuse to give your consent to treatment.*

I request and consent to chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays. The chiropractic treatment may be performed by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic working at this clinic or office. Chiropractic treatment may also be performed by a Doctor of Chiropractic who is serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of my chiropractic treatment, the risks and benefits of my chiropractic treatment, alternatives to my chiropractic treatment, and the risks and benefits of alternative treatment, including no treatment at all.

I understand that, there are some risks to chiropractic treatment including, but not limited to:

- ☐ Broken bones
- ☐ Dislocations
- ☐ Sprains/strains
- ☐ Burns or frostbite (physical therapy)
- ☐ Worsening/aggravation of spinal conditions
- ☐ increased symptoms and pain
- ☐ No improvement of symptoms or pain
- ☐ Infection (acupuncture)
- ☐ Punctured lung (acupuncture)
- ☐ Other _____

In rare cases there have been reported complications of vertebral artery dissection (stroke) when a patient receives a cervical adjustment. The complications reported can include temporary minor dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death.

I do not expect the doctor to be able to anticipate and explain all risks and complications. I also understand that no guarantees or promises have been made to me concerning the results expected from the treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my current condition.

To be completed by the patient:

_____
print name

_____
signature of patient

_____
date signed

To be completed by the patient's representative:

_____
print name of patient

_____
print name of patient's representative

_____
signature of patient's representative

as:_____
relationship/authority of patient's representative

_____
date signed

To be completed by doctor or staff:

_____
witness to patient's signature

_____
translated by

_____
date

_____
date

Cove Freedom Chiropractic

211 Liberty Bell Lane, Suite 111
Copperas Cove, Tx 76522

Clinic Policies

The following is an explanation of our clinic policies. We believe that a clear definition will allow us all to concentrate on the most important issue. Regaining and maintaining your health.

No Charge Consultation
Cove Freedom Chiropractic Clinic will do a special "no charge" consultation, or brief conference, with anyone interested in finding out if chiropractic can help them with their individual health problems. There is no charge or obligation in connection with this appointment.

New Patient Care Services
We require the payment in full on the first visit unless prior arrangements are made. Then the balance of these charges may be made in payments over the course of your treatment schedule. Properly documented auto accident claims are not required to pay at this time if appropriate forms and liens are signed.

Established Patient Care
Patients under care are required to make regular payments on all unpaid balances except for properly documented auto injury claims. Payments need to be made according to prior arrangements. We reserve the right to charge finance charges and late fees to any account that is not paid in a timely manner.

Appointments
In order to better serve our patients, we ask that you call if you need to reschedule your appointment or if you will be late. Your appointment time is reserved for you. If you fail to notify our office, it leaves a time slot open that could have been used to help someone else. Please help us help others.

Questions and Answers
Your questions about any aspect of your care and account are invited. Please feel free to ask your doctors or staff members. We will make every effort to answer your inquiries.

Payments
Payments for office visits are due the same day as your office visits unless other documented arrangements have been made, such as our Cove Freedom Finance plan, Special Consideration payment Plan, or our Cove Freedom Membership plan.

I have read the Cove Freedom Chiropractic Clinic Policies and will honor them.

Patient's Signature_____ **Date**_____/_____/_____